PEDIATRIC PATIENT HISTORY

Child's Name _____ Age Today _____ Date _____

Previous Physician _____ Referred By _____

BIRTH HISTORY:

Date of Birth _____ Hospital _____ Birthweight_____

Prenatal Problems? Yes_____No_____ If Yes, please list_____

Full Term or Premature?_____ Delivery? Vaginal_____ C-Section_____

As Infant, any Reflux? _____ Formula or Milk intolerances?_____ Please detail_____

SOCIAL HISTORY:

Mother's name _____Age_____Health_____

Father's name_____Age_____Health_____

Brother/Sister_____Age_____Health_____

Brother/Sister_____Age_____Health_____

Brother/Sister_____Age_____Health_____

Brother/Sister_____Age_____Health_____

Who does child live with? _____

Parents' marital status: Married_____Divorced_____Never Married_____Separated_____Widowed_____

If divorced, who has legal custody?_____

Child's School_____Grade_____Grades: Above Average_____Average_____Poor_____

RISK FACTORS:

Smoker's in home? Yes_____No_____ Who?_____

Smoke detector in home? Yes_____No_____

Guns in home? Yes_____No_____ If Yes, are they unloaded?_____Locked?_____

Seat Belt Use? Yes_____No_____ Car seat use? Yes_____No_____ Use of bicycle helmet? Yes_____No_____

ALLERGIES AND SENSITIVITIES:

List any allergies to medications or foods that you have and indicate how each affects you

Allergic to:_____ Reaction_____

Allergic to:_____ Reaction_____

Allergic to:_____ Reaction_____

For Girls: Age at first period? _____ Date of last period _____

List any problems associated with periods _____

PAST MEDICAL HISTORY: (check all that apply and detail / indicate when)

- ○ Bedwetting _____
- ○ Hives/Skin Problems _____
- ○ Infectious Mononucleosis (mono) _____
- ○ Measles _____
- ○ Pneumonia _____
- ○ Mumps _____
- ○ Roseola _____
- ○ Strep Throat or Scarlet Fever _____
- ○ Asthma or Wheezing _____
- ○ Seizures _____
- ○ Sutures or Staples _____
- ○ Heart Murmur _____
- ○ Behavior Problems _____
- ○ Bladder / Urine Infection _____
- ○ Bowel Problems _____
- ○ Chickenpox _____
- ○ Diabetes _____
- ○ Ear Infections _____
- ○ Fainting _____
- ○ Fractures / Broken Bones _____
- ○ Head Injury / Concussion _____
- ○ Chronic Pain _____
- ○ ER visit: Where & Why? _____
- ○ Hospitalizations: Where & Why? _____

NUTRITIONAL HISTORY:

Has there been any change in your appetite in the past 6 months? Yes_____ No_____

Have you gained or lost weight recently without wanting to? Yes_____ No_____

If yes, how much? _____

Are you happy with your weight? Yes _____ No _____

If not, are you on a diet or exercise program? Yes _____ No _____

Do you exercise regularly? Yes _____ No _____

How many caffeinated drinks (cups/cans) do you have per day? _____coffee _____tea _____soda

Family History:	None	Mother	Father	Sister / Brother	Grand - Parent	Aunt / Uncle
Arthritis (before age 50)						
Asthma						
Bleding Disorder						
Childhood Cancer						
Convulsions / Selzures						
Developmental Delay or Mental Retardation						
Diabetes						
Heart Disorder						
Heart Attack (before age 40)						
High Cholesterol						
History of Birth Defects in Family						
History of Sudden Infant Death (SIDS) in Family						
Hypertension (high blood pressure) (before age 50)						
Hypoglycemia (low blood sugar)						
Kidney / Bladder Disorder / If yes, please detail						
Nerve or Muscle Disorder / If yes, please detail						
Stroke (before age 40)						
tuberculosis (TB)						
Other / Comments						